Docket No.: MMX-CV18-5010661-S	**: Superior Court**
	:
Gloria Drummer,	**:**
	:
Plaintiff, Individually and on behalf of all persons similarly situated,	**:**
	: Judicial District of
	: Middlesex
v.	**: at Middletown**
	:
State of Connecticut, et al.,	**:**
	:
Defendants.	**: September 25, 2019**

OBJECTION TO MOTION TO STRIKE

The Supreme Court of Connecticut clearly stated more than twenty-nine years ago that there is no sovereign immunity for claims under the Connecticut Patients' Bill of Rights in *Mahoney v. Lensink*, 213 Conn. 548 (1990). In disregard of a clear precedent, and without attempting to distinguish *Mahoney v. Lensink*, the State claims that it has sovereign immunity from a claim by the plaintiff in this matter brought pursuant to General Statutes § 17a-541, § 17a-542 and § 17a-550. The State's assertion in their motion to strike is that the statutory term "civil rights" does not include the legal right of individuals to be discharged to the most integrated setting in the community within a reasonable period of time after they no longer meet the legal standard for commitment. That assertion is contrary to the purpose of the Connecticut Patients' Bill of Rights and the

rule of statutory construction that directs the statute be broadly and liberally construed to effect the remedial purpose of the legislation.

1. "Civil Rights" Provided for in General Statutes § 17a-541 Includes the Right to be Discharged to the Most Integrated Setting from a State Hospital.

Plaintiff does not claim a violation of the Americans with Disabilities Amendment Act. Plaintiff claims that the Connecticut Patients' Bill of Rights, § 17a-541, and its use of the term "civil rights," includes a right to be discharged from a state psychiatric hospital to the most integrated setting within a reasonable period of time. Section 17a-541 states that, "No patient hospitalized or treated in any public or private facility for the treatment of persons with psychiatric disabilities shall be deprived of **any personal, property or civil rights**, . . ." (Emphasis added.) The clear unambiguous words of the statute indicate that a patient shall not be deprived of any civil right. The defendants wish that the statute said "a few civil rights," or "only state rights previously mentioned by the Supreme Court," or "only rights in existence prior to 1971." The term any "civil rights" in § 17a-541 is not defined in the statute and should be construed broadly, as required by *Mahoney v. Lensink*, 213 Conn. 548, 556 (1990). The Supreme Court stated, "Because the patients' bill of rights is remedial

in nature, its provisions should be liberally construed in favor of the class sought to be benefited."

Consistent with the rule of liberal construction of a remedial statute, the Supreme Court, in *Mahoney v. Lensink*, 213 Conn. 548, 570 (1990) stated, "We are therefore persuaded that the freedom from deprivation of 'any personal, property, or civil rights' provided in § 17-206b includes not only those statutory rights expressly enumerated, but necessarily incorporates as well the freedom from deprivation of 'any rights, privileges, or immunities secured by the Constitution' as guaranteed under 42 U.S.C. § 1983." The Court did not mention 42 U.S.C. § 1983 as a term of limitation or exclusivity, but one of inclusion of a broad array of civil rights relevant to the case before it.

The Court stated that the term "civil rights" should be construed broadly because the plain language of the statute itself in § 17a-541 requires it:

> Because the statutory itemization in § 17-206b speaks of "personal, property or civil rights, *including* the right to vote, hold or convey property, or contract," (emphasis added) the defendant's contention is unpersuasive. The legislature's use of the word "including" rather than the commonly utilized expression, "shall include," evinces an intention to provide an expansive interpretation of the rights protected by § 17-206b."

Mahoney v. Lensink, 213 Conn 548, 569 (1990)

In *Mahoney v. Lensink*, the State argued that the term "civil rights" included only the rights expressly stated: the right to vote, hold or convey property, or contract. The Court was unpersuaded. The Court stated that the civil rights provided for in the statute must be construed broadly and liberally to fulfill the purpose of the statute to protect the class of people, patients in psychiatric facilities, afforded the protection of the law. The defendants would like to have a short, specific, limited list of civil rights in the statute. The legislature, consistent with its intended purpose of attempting to stop decades of abuse provided a broad mandate that no patient shall be deprived of any civil right.

The State also shockingly argued in *Mahoney v. Lensink*, at 564, that the right to treatment in § 17-206c, now § 17a-542, which provides for humane and dignified treatment, "should be limited to 'abstinence from procedures – such as strip searches, beatings, or deprivation of food – that would obviously fall short of the ideal." This is an outrageous position and was rejected by the Court.

Another example of liberal construction of the Connecticut Patients' Bill of Rights came in 1999, when the Supreme Court again broadly construed the remedial statute in favor of the class of patients in *Phoebe G. v. Solnit*, 252 Conn. 68 (1999). The Supreme Court held that under § 17a-

542, the right to humane and dignified treatment and a discharge plan, included the right to be present at treatment team meetings and the right to have an advocate be present with the patient, even if the patient had a conservator who refused to sign an authorization for release of medical information for the advocate. Nowhere in § 17a-542 does the statute expressly provide for the right to be present at the treatment team meeting or the right to an advocate. Nor is the right to be present or the right to an advocate provided for by 42 U.S.C. § 1983. The Court simply stated that the statute should be broadly construed and that the terms of the statute implied such rights.

Finally, in *Beshara v. Charlotte Hungerford Hospital Center for Behavioral Health*, No. CV1360089907S, Superior Court, Judicial District of Litchfield, 57 Conn. L. Rptr. 546 (2014), 2014 WL 660486 (Case attached as Attachment A.) Judge Wilson J. Trombley held, "This court finds that an alleged interference with a psychiatric patient's exercise of civil rights afforded by the ADA is conduct that the psychiatric patient bill of rights makes actionable." *Beshara*, at *14. The Court noted that such interference was actionable under the Connecticut Patients' Bill of Rights, § 17a-541, even though the ADA is not actionable under 42 U.S.C. § 1983. *Beshara* at *14.

A patient in a facility, as defined in the Connecticut Patients' Bill of Rights § 17a-540(1) and (2), clearly has the important civil right to be discharged to the most integrated setting within a reasonable period of time, as provided for in the Americans with Disabilities Amendment Act, 42 U.S.C. § 12132, 42 C.F.R. § 35.130(d); the Rehabilitation Act, 29 U.S.C. § 794, 28 C.F.R. §41.51(d); and *Olmstead v. L.C.*, 527 U.S. 581, 607 (1990). The Supreme Court in *Olmstead* clearly held that people with disabilities have a civil right to receive state services, programs and activities in the most integrated setting; that unjust segregation is discrimination prohibited by the ADA and that unjustified institutional isolation of persons with disabilities is a form of discrimination. *Olmstead* at 600. The civil right to be discharged to the most integrated setting is a firmly established and long-held civil right of patients in state psychiatric facilities. It is a civil right that must be enforceable through the Connecticut Patients' Bill of Rights, § 17a-541, § 17a-542 and § 17a-550. The Connecticut Patients' Bill of Rights incorporates all of the civil rights and discharge rights of a patient in a facility and gives them a private right of action against the facility, whether it is public or private.

2. The DMHAS Commissioner Has Established a Written Formal Policy Providing for The Civil Right to Discharge to the Most Integrated Setting in Commissioner's Policy 6.41.

The Commissioner of the Department of Mental Health and Addiction Services, Whiting Forensic Hospital and Connecticut Valley Hospital all have policies providing for a right of discharge to the most integrated setting. Commissioner's Policy 6.41 (Attached as Attachment B.) was extracted as the last policy change demanded by the United States Department of Justice and the Connecticut Legal Rights Project in *United States v. Connecticut*, No. 3:09-cv-85 (D. Conn 2009) in order to achieve substantial compliance with the settlement agreement and to close out federal court supervision. The Commissioner's Policy includes the statements, "1. Planning for discharge to the most integrated setting begins upon admission to the inpatient service. . .3. Discharge planning must be directed toward the most integrated, least restrictive environment appropriate for each individual, maximizing the individual's opportunity to interact with persons who do not have disabilities and take into account the informed choice of the individual or his/her conservator with authority, . . ." The policies for Connecticut Valley Hospital and Whiting Forensic Hospital are almost identical. (CVH Policy 2.38 and WFH Policy 2.38 are attached as Attachments C and D respectively.) After Olmstead and

Commissioner's Policy 6.41, no state actor has ever legitimately asserted that patients in state psychiatric facilities do not have a civil right to be discharged to the most integrated setting in a timely manner.

3. The Civil Rights Provided for in the Connecticut Patients' Bill of Rights are Not Frozen in time in 1971.

The State does not argue that General Statutes § 17a-541 or § 17a-542 do not provide for civil rights or that the right to be discharged to the most integrated setting is not a civil right. Instead, the State appears to argue that plaintiffs are asserting a claim under the ADA and that the Connecticut Patients' Bill of Rights protection for civil rights is frozen in time and therefore the State has sovereign immunity for any civil right recognized after 1971. This assertion is profoundly misguided.

Nowhere does the Supreme Court in *Mahoney* state that the statutory term, "civil rights," is frozen in time or limited to rights protected through § 1983. Reading the Connecticut Patients' Bill of Rights in such a restrictive fashion would ignore everything else the court stated about the rules of statutory construction and the purpose of the statute as a whole.

The State argues that the Supreme Court did not address incorporating statutory rights in *Mahoney v. Lensink*. But the Supreme Court did incorporate the federal statute, 42 U.S.C. § 1983 and therefore all of the constitutional and federal statutory rights enforceable through §

1983. It limited its incorporation to that federal statute because that was the claim that was before it in that case. Mahoney was a wrongful death damages action for monetary relief brought by the parents in their individual capacity and as administrators of their son's estate. Counts one through nine were essentially negligence, gross negligence and willful, wanton and reckless claims against the commissioners of state agencies responsible for safety, training and supervision regarding patients at Norwich State Hospital. In this case, Gloria Drummer brings her complaint as a proposed class action for prospective injunctive relief and declaratory relief only.

The Supreme Court in *Mahoney* did not limit the scope of "civil rights" or "humane and dignified treatment" to the constitutional and statutory rights enforceable through § 1983. It merely stated that the Connecticut Patients' Bill of Rights includes those rights. The Connecticut Supreme Court clearly stated that the Connecticut Patients' Bill of Rights should be liberally construed as a remedial statute to fulfill the purpose of the legislature, to prevent the shocking abuse of patients in state psychiatric hospitals by giving them a private right of action against the state for violation of all of their civil rights and for a positive, meaningful right to treatment and discharge.

4. The State's Motion to Strike Paragraph 33 Alone Does Nothing to Limit Plaintiff's Claims Pursuant to the Connecticut Patients' Bill of Rights.

Defendants move to strike paragraph 33 because "[a]ny alleged violation of the Americans with Disabilities Act is not actionable conduct under the Connecticut Bill of Rights." (Sic) The Defendant misconstrues Plaintiff's complaint in order to argue a case they would prefer to defend, instead of the case that is pled. The Plaintiff's complaint alleges a violation of the Connecticut Patients' Bill of Rights, § 17a-541 and § 17a-542, not the Americans with Disabilities Amendment Act. She asserts that the term "civil rights" includes the clearly-established civil right to be discharged from a state hospital to the most integrated setting.

Paragraph 34 of the complaint clearly alleges that General Statutes § 17a-541 includes the statutory right, memorialized in the Commissioner's Policy 6.41, to discharge to the most integrated setting within a reasonable time after no longer meeting the legal standard for commitment. Striking paragraph 33 leaves the claim intact from a fair reading of the entire complaint in general and paragraph 34 in particular.

Paragraph 35 makes the same assertion with respect to discharge rights provided for in General Statutes § 17a-542. Paragraph 35 includes the assertion that "The right to discharge to the most integrated setting

within a reasonable period of time after a patient no longer meets commitment standards should be incorporated into Conn. Gen. Stat. § 17a-542."

There is a split of authority as to whether a motion to strike can address only a particular paragraph or must attack an entire count or cause of action. See, 1 Conn. Prac. Super. Ct. Civ. Rules § 10-38 (2018 ed.) The commentators, Wesley Horton and Kimberly Knox, state, "Most rule that a paragraph may be subject to a motion to strike if it encompasses an entire cause of action or defense." *Id.* Since the defendants' motion to strike does not encompass the entire cause of action, it is procedurally deficient and should be denied.

Striking only paragraph 33 does not diminish Plaintiff's legal claim that state law, the Connecticut Patients' Bill of Rights, §§ 17a-541 and 17a-542, includes the right to be discharged to the most integrated setting. The State defendants have not asserted that plaintiff does not have right to be discharged to the most integrated setting. Their assertion is only that they do not accept citation to the Americans with Disabilities Act as one of the bases for that right. Since the State defendants accept the allegations of paragraphs 34 and 35, which merely assert the civil right to be discharged to the most integrated setting, the motion to strike should be

denied. "When some of the allegations contained in a count are sufficient to set forth a cause of action, the court is not permitted to strike the entire count." *Law Office of Norman Voog, LLC v. Stevens*, No. CV020347140S, page 3, Superior Court, Judicial District of Danbury (2004). (Attached as Attachment E.) The State's attempt to strike the legal reference to the source of the state civil right, but not the substance of the right itself, should lead the Court to deny the motion to strike paragraph 33.

Respectfully submitted,

The Plaintiff,

By: /s/429577
Kirk W. Lowry, Juris No. 429577
Legal Director
Kathy Flaherty, Executive Director
Karyl Lee Hall, Senior Attorney
Sally Zanger, Senior Attorney
Virginia Teixeira, Staff Attorney
Connecticut Legal Rights Project
P.O. Box 351 Silver Street
Beers Hall 2nd Floor
Middletown, CT 06457
(860) 262-5017
(860) 262-5035 – fax
klowry@clrp.org

Certification

I hereby certify that a copy of the above was electronically delivered on September 25, 2019 to all counsel and pro se parties of record and that written consent for electronic delivery was received from all counsel and pro se parties of record who were electronically served.

Henry Salton, henry.salton@ct.gov
Jennifer Callahan, jennifer.callahan@ct.gov,
Laura D. Thurston, laura.thurston@ct.gov

/s/429577
Kirk W. Lowry

Attachment A

Beshara

v.

Charlotte Hungerford Hospital Center for Behavioral Health

2014 WL 660486

Superior Court of Connecticut,
Judicial District of Litchfield.

Teresa BESHARA
v.
CHARLOTTE HUNGERFORD HOSPITAL CENTER FOR BEHAVIORAL HEALTH.

No. CV136008907S.
|
Jan. 21, 2014.

Synopsis
Background: Former mental health patient filed complaint against treatment facility for alleged violations of psychiatric patient bill of rights. Facility moved to dismiss for lack of personal jurisdiction.

Holdings: The Superior Court, Wilson J. Trombley, J., held that:

[1] as matter of first impression, claims for violations of Connecticut's psychiatric patient bill of rights are not subject to requirements of a medical malpractice action of obtaining written opinion of similar health care provider and attaching opinion to certificate of good faith;

[2] an alleged interference with a psychiatric patient's exercise of civil rights afforded by the Americans with Disabilities Act (ADA) is conduct that the psychiatric patient bill of rights makes actionable; and

[3] facility's alleged wrongful failure to order appropriate medications was conduct that psychiatric patient bill of rights made actionable.

Motion denied.

West Headnotes (3)

[1] **Health**
Affidavits of merit or meritorious defense; expert affidavits

Claims for violations of the psychiatric patient bill of rights are not subject to the requirements of a medical malpractice action of obtaining the written opinion of a similar health care provider that there appears to be evidence of medical negligence and of attaching the opinion to the certificate of good faith to be filed with the complaint. C.G.S.A. §§ 17a–541, 17a–542, 17a–544(b), 52–190a.

5 Cases that cite this headnote

[2] **Civil Rights**
Medical facilities and services

An alleged interference with a psychiatric patient's exercise of civil rights afforded by the Americans with Disabilities Act (ADA) is conduct that the psychiatric patient bill of rights makes actionable. Americans with Disabilities Act of 1990, § 2(b)(1), 42 U.S.C.A. § 12101(b)(1); C.G.S.A. § 17a–541.

2 Cases that cite this headnote

[3] **Health**
Pharmacological services

Allegations by former mental health patient that treatment facility wrongfully failed to order the appropriate medications was conduct that the psychiatric patient bill of rights, requiring that every patient treated in any facility for treatment of persons with psychiatric disabilities receive humane and dignified treatment, made actionable. C.G.S.A. § 17a–542.

2 Cases that cite this headnote

Opinion

WILSON J. TROMBLEY, Judge.

***1** The issue before the court is whether to grant the defendant's motion to dismiss the plaintiff's complaint for lack of personal jurisdiction based on the failure to attach a certificate of good faith or the written opinion of a similar health care provider, pursuant to General Statutes sec. 52–190a. The motion to dismiss is denied.

I

NATURE OF THE PROCEEDINGS

This case arises out of a dispute between a former mental health patient and her healthcare provider. On June 19, 2013, the plaintiff, Theresa Beshara, filed a three-count complaint against the defendant, Charlotte Hungerford Hospital Center for Behavioral Health, pursuant to General Statutes sec. 17a–550, which permits a civil action against a mental health treatment facility for damages resulting from a violation of the psychiatric patient bill of rights, General Statutes sec. 17a–540 et seq.[1]

Count one alleges that the defendant deprived the plaintiff of her right to

independently contract with an employer and to negotiate lawful accommodations pursuant to the Americans with Disabilities Act ("ADA"), in violation of General Statutes sec. 17a–541.[2] The following facts are alleged in this count. As of March 1, 2011, the plaintiff had been diagnosed with schizophrenia, residual type; obsessive compulsive disorder; and pathological gambling—all diagnoses which place the plaintiff within the class of persons entitled to reasonable workplace accommodations pursuant to the ADA. The defendant had been the exclusive provider of mental health services to the plaintiff for almost six years.

On March 18, 2011, by telephone, the plaintiff notified the defendant of her intent to pursue an *unspecified* workplace accommodation under the ADA. On March 21, 2011, the plaintiff was seen by her clinician, Kathleen Thayer, A.P.R.N., who is employed by the defendant. The request for workplace accommodations was discussed during this medication review session and the plaintiff requested a letter for her *unnamed* employer. Thayer did not provide any such documentation. The plaintiff made another request for a letter on March 28, 2011. On that date, the plaintiff was provided with "a terse handwritten letter," "scrawled on a piece of letterhead that was not suitable for use in negotiations with her employer." The plaintiff was also provided with a handwritten note which stated: "If you think this will help—you can give this to your employer. However, I will *not speak to your employer without seeing you first and discussing the purpose. Take care.*" (Emphasis in original.) On March 31, 2011, the plaintiff met with Thayer to discuss her request for accommodation at work, although Thayer contends that the meeting was scheduled to discuss medication.

On April 5, 2011, the plaintiff submitted a written request for a letter to verify her diagnosis of OCD for discrimination purposes and to support an appeal. The plaintiff was advised that job performance is not within Thayer's or the defendant's ability to assess in line with the plaintiff's symptoms. A treatment note, on April 6, 2011, indicates that the defendant's medical director and multidisciplinary staff advised that a letter commenting on job performance and supporting documentation could not be provided.

***2** In response to a phone call requesting that the letter be sent, the plaintiff was advised to "come in to discuss her symptoms and behavior and her perception of employer motives." The plaintiff made multiple phone calls to the defendant requesting a letter for her employer, which the defendant continually refused to supply, advising the plaintiff that her behavior was "quite obsessive and may be symptomatic." Ultimately, on April 18, 2011, the plaintiff was provided with a handwritten letter, stating that she was not disabled, and noting that "however, due to your disorders your symptoms can exacerbate which requires increased doses of medication ."

Count two alleges that "the defendant used medication as a substitute for a habilitation program in violation of General Statutes sec. 17a–544(b),[3] but simultaneously, in violation of General Statutes sec. 17a–542,[4] with gross disregard for the dignity of the patient and with a lack of regard for health and welfare of the patient, failed to order the

appropriate medications from the pharmacy." Count two incorporates *all* of the factual allegations contained in count one, and alleges, further, that on March 21, 2011, the plaintiff was seen for a medication review, medications were prescribed and a follow-up appointment was scheduled for May 16, 2011. However, on March 31, 2011, during the period when the plaintiff was requesting accommodation letters, the defendant increased the dosages of her medications, and authorized refills sufficient through June. On April 13, 2011, the defendant instructed the plaintiff to again increase the dosage of one of her medications. This increased dosage, however, was not called into a pharmacy.

On May 9, 2011, the plaintiff called the defendant because the increased dosage, authorized on April 13, 2011, was not adequately provided for by prescription and she was running low on the medication. The defendant refused to provide the plaintiff with any medication, informing her that she would need to be seen first. The plaintiff was seen by the defendant on May 16, 2011, as previously scheduled. After this appointment, the plaintiff made multiple calls to the defendant seeking medication, but was not accommodated. Rather, the plaintiff was advised that she needed to be evaluated. On May 23, 2011, the plaintiff arrived for an evaluation but, after waiting one hour, she left without being seen. On May 31, 2011, the plaintiff was administratively discharged from services.

The complaint alleges that between May 27, 2011, and May 31, 2011, the plaintiff made over thirty phone calls to the defendant requesting medication, and requesting to speak with managers and the hospital president because the plaintiff was desperate to have proper medication; between May 9, 2011, and May 31, 2011, no clinician from the defendant reviewed the plaintiff's chart to determine whether she needed medication; and between March 21, 2011, and May 31, 2011, twelve separate appointments were scheduled for the plaintiff in an effort to medicate her and deter her from exercising her rights under the ADA because the defendant believed that the plaintiff's demand for an accommodation letter was a reflection of clinical decompensation.

***3** The complaint further alleges that the plaintiff followed the treatment schedule set forth by the defendant, but, nonetheless, was deprived of the medication she was instructed to take. The defendant's treatment of the plaintiff was "demeaning, demoralizing, humiliating, cruel and unnecessary, and it constituted a violation of her right to be treated humanely by her mental health treatment provider."

Count three alleges that "the defendant failed to develop or implement a discharge plan for the plaintiff, failed to provide reasonable notice of her impending discharge, failed to include the plaintiff in planning for her discharge, and failed to plan for appropriate aftercare of the patient, all in violation of General Statutes sec. 17a–542." Count three incorporates *all* of the factual allegations contained in counts one and two, and further alleges that the plaintiff's discharge from treatment on May 31, 2011, was unplanned and the circumstances of the discharge were not in accordance with a designed treatment plan. The plaintiff asserts

that the defendant knew or should have known that, at the time of the discharge, the plaintiff lacked an adequate supply of medication, the plaintiff did not have a new medical provider, and the plaintiff was not clinically stable.

On July 16, 2013, the defendant filed the present motion to dismiss for lack of personal jurisdiction (# 101). The plaintiff filed an objection to the motion to dismiss on August 1, 2013 (# 105). The defendant filed a reply memorandum on August 15, 2013 (# 109). The matter was heard on the October 15, 2013 short calendar.

II

MOTION TO DISMISS

"[A] motion to dismiss ... properly attacks the jurisdiction of the court, essentially asserting that the plaintiff cannot as a matter of law and fact state a cause of action that should be heard by the court." (Internal quotation marks omitted.) *Santorso v. Bristol Hospital,* 308 Conn. 338, 350 (2013). Among "[t]he grounds which may be asserted in [a motion to dismiss] are ... lack of jurisdiction over the person ... [and] insufficiency of service of process." *Zizka v. Water Pollution Control Authority,* 195 Conn. 682, 687, 490 A.2d 509 (1985), citing Practice Book sec. 143, which is now sec. 10–31. "When a trial court decides a jurisdictional question raised by a pretrial motion to dismiss on the basis of the complaint alone, it must consider the allegations of the complaint in their most favorable light ... In this regard, a court must take the facts to be those alleged in the complaint, including those facts necessarily implied from the allegations, construing them in a manner most favorable to the pleader." (Internal quotation marks omitted.) *Conboy v. State,* 292 Conn. 642, 651, 974 A.2d 669 (2009).

III

CLAIMS OF THE PARTIES

The defendant moves to dismiss on the ground that the court lacks personal jurisdiction because the plaintiff's complaint sounds in medical malpractice, but the plaintiff failed to attach a certificate of the good faith basis and a written opinion of a similar healthcare provider,[5] as required by General Statutes sec. 52–190a.[6] The defendant relies on *Trimel v. Lawrence & Memorial Hospital Rehabilitation Center,* 61 Conn.App. 353, 357–58, 764 A.2d 203, appeal dismissed, 258 Conn. 711, 784 A.2d 889 (2001), in which the court set forth the relevant considerations to determine whether a claim sounds in medical malpractice or ordinary negligence: "[W]hether (1) the

defendants are sued in their capacities as medical professionals, (2) the alleged negligence is of a specialized medical nature that arises out of the medical professional-patient relationship and (3) the alleged negligence is substantially related to medical diagnosis or treatment and involved the exercise of medical judgment."

***4** The defendant asserts that the plaintiff's complaint satisfies the *Trimel* test for medical malpractice. First, the defendant contends that the cause of action lies against the defendant's therapists in their capacity as medical professionals. Second, the defendant asserts that the negligence alleged by the plaintiff—the failure to provide a letter to support her request for a workplace accommodation, negligent prescription and dispensing of medication, and the failure to design and implement a discharge plan—are of a specialized medical nature arising from the plaintiff's relationship with her treaters. In fact, the defendant contends, at least one Superior Court has determined that allegations of negligent prescription and dispensing of medication are medical malpractice claims requiring written opinion letters; *Simmons v. CVS Pharmacy, Inc.,* Superior Court, judicial district of Fairfield, Docket No. CV–08–5021084–S (June 17, 2009, *Hiller, J.*);[7] and that our Supreme Court has ruled that "the administration of prescription medication is of a specialized medical nature and requires the exercise of medical judgment ..." *Boone v. William W. Backus Hospital,* 272 Conn. 551, 564, 864 A.2d 1 (2005). Finally, the defendant argues, each claim of alleged negligence by the plaintiff is substantially related to medical diagnosis or treatment, and involved the exercise of medical judgment. Specifically, in count one, the plaintiff claims that the defendant believed her requests for an accommodation letter represented an escalation of her symptoms of mental illness and determined that such a letter could not be provided. According to the defendant, the claimed negligent failure to provide the letter is both related to medical diagnosis and constitutes an exercise of medical judgment. Next, count two alleges that the defendant increased the plaintiff's dosage of medications but never advised the dispensing pharmacies that the doses had been increased. These alleged omissions, the defendant asserts, related to medical treatment and are an explicit exercise of medical judgment. Likewise, the claimed negligence in count three, i.e., the failure to create and implement a proper treatment and discharge plan, also arise from medical treatment and judgment.

In contrast, the plaintiff argues that her claims do not sound in medical malpractice. According to the plaintiff, the facts alleged in the complaint reveal that the dispute between the plaintiff and the defendant stems from a decision by the plaintiff to exercise her federal statutory rights by way of seeking an accommodation pursuant to the ADA. The core allegations are that the defendant interfered with the plaintiff's exercise of her rights under the ADA; that her treatment during the conflict was inhumane; and that her discharge from care was unplanned and did not meet the requirements of the statutory protections. According to the plaintiff, the psychiatric patient bill of rights permits her to bring a direct suit for the damages resulting from the defendant's violation of these statutory protections. Furthermore, the plaintiff argues

that the psychiatric patient bill of rights operates independently of common law negligence, forms an entirely new tort and a violation of the statute, alone, is actionable.

***5** In reply, the defendant argues that, to sufficiently state a claim for violation of the psychiatric patient bill of rights, the plaintiff's allegations must rise above negligence, but, the plaintiff's complaint fails in this respect, alleging only negligent treatment. In fact, the defendant asserts, the plaintiff does not even allege any violation of an existing right, as she does not claim, in particular, that she was unable to secure a workplace accommodation under the ADA. Rather, she claims nothing more than negligent treatment of her psychiatric condition. Indeed, according to the defendant, an exercise of medical judgment is claimed in that, despite knowing that the plaintiff sought a workplace accommodation, the defendant made a determination that the plaintiff's requests were a sign of progression of her mental illness.

IV

DISCUSSION

A

Applicable Law

General Statutes sec. 52–190a(a), which requires the filing of a certificate of good faith and an opinion of a similar health care provider, only applies if the cause of action is for medical malpractice. As noted by the defendant, the test for whether an action is one for medical malpractice or negligence is set forth in *Trimel v. Lawrence & Memorial Hospital Rehabilitation Center, supra,* 61 Conn.App. at 357–58, 764 A.2d 203. However, in this court's view, the issue presented is not whether the plaintiff has alleged a claim for ordinary negligence as opposed to medical malpractice, but rather is whether the plaintiff's statutory cause of action under the psychiatric patient bill of rights is a claim for "medical negligence," which requires compliance with General Statutes sec. 52–190a(a).

Although not dispositive of the issue, it is notable that in *Scherer v. Waterbury,* Superior Court, judicial district of Waterbury, Docket No. CV–97–0137073–S (February 22, 2000, Pellegrino, J.),[8] the plaintiff alleged, *inter alia,* a violation of General Statutes sec. 17a–542, in count one, and medical malpractice, in count eight, arising out of the plaintiff's care and treatment at Waterbury Hospital. The court found that, although the factual basis for the plaintiff's claim that "the defendants violated the patient's bill of rights is similar to the basis for her claim of medical malpractice ... the allegations are different. The first count finds fault with the alleged inhumane and undignified treatment of the plaintiff resulting when the defendant employees of Waterbury Hospital forced the plaintiff into a secluded room and forced her

to disrobe while in the presence of a male security guard. The first count is not based upon negligence, but intentional conduct. Whereas, the eighth count, sounding in medical malpractice, contains an allegation that the defendants failed to provide the plaintiff with a prompt and adequate mental status examination prior to implementing force." *Id.* The court denied the defendant's motion to strike on the ground that "[a]lthough the first count and eighth count arise from the same factual circumstance, the first count is not negligence recast." *Id.;* see *Campbell v. Charlotte Hungerford Hospital,* Superior Court, judicial district of Litchfield, Docket No. CV04–0092783–S (April 27, 2005, Pickard, J.) (section 52–190a did not apply to alleged violation of General Statutes sec. 17a–546 for failure to permit plaintiff to make telephone calls because it was not an action to recover damages for personal injury resulting from negligence).

***6** One court has also reviewed a plaintiff's claim of employment discrimination under the psychiatric patient bill of rights. In *Doe v. Odili Technologies, Inc.,* Superior Court, judicial district of Danbury, Docket No. CV–97–0327738–S (November 18, 1999, Moraghan, J.), the court held that the requirements of the Connecticut Fair Employment Practices Act ("CFEPA") were not applicable to General Statutes sec. 17a–549 and, therefore, the plaintiff was "under no obligation to pursue and exhaust administrative remedies as a prerequisite" to bringing a claim under sec. 17a–549. The court noted that although "[b]oth statutes address the issue of employment rights of employees with a present or past history of mental disorders," the CHRO does not have "exclusive jurisdiction over the issue of employment discrimination based on a mental disorder" and General Statutes sec. 17–206k, now, General Statutes sec. 17a–550, "expressly and specifically provides for a civil action in the Superior Court." *Id.* The court explained that "[t]he plaintiff had a choice as to the statute under which to pursue her claim of discrimination."

As there is no appellate authority, or superior court guidance, on the precise issue before this court, a careful review of the statutory language and the public policies attending the enactment of the psychiatric patient bill of rights and General Statutes sec. 52–190a is warranted. This court must follow the dictate of our Supreme Court that "[a] statute should be interpreted according to the policy which the legislation seeks to serve." *Aaron v. Conservation Commission,* 183 Conn. 532, 538, 441 A.2d 30 (1981).

General Statutes sec. 52–190a(a) requires the plaintiff in a medical malpractice action to obtain the written opinion of a similar health care provider that "there appears to be evidence of medical negligence" and to attach the opinion to the certificate of good faith to be filed with the complaint. However, "[s]ection 52–190a(a) does not define medical negligence ..." *Dias v. Grady,* 292 Conn. 350, 356, 972 A.2d 715 (2009). Our Supreme Court has determined that "medical negligence" as used in General Statutes sec. 52–190a(a) means "breach of the standard of care ..." *Dias v. Grady, supra,* at 359, 972 A.2d 715. The written opinion must set forth "the basis of the similar health care provider's opinion that there appears to be evidence of medical

negligence by express reference to what the defendant did or failed to do to breach the applicable standard of care. In other words, the written opinion must state the similar health care provider's opinion as to the applicable standard of care, the fact that the standard of care was breached, and the factual basis of the similar health care provider's conclusion concerning the breach of the standard of care." *Wilcox v. Schwartz,* 303 Conn. 630, 643 (2012).

As previously noted, *Trimel v. Lawrence & Memorial Hospital Rehabilitation Center, supra,* 61 Conn.App. at 357–58, 764 A.2d 203 sets forth a three-part test for determining whether a claim sounds in medical malpractice or ordinary negligence: "[W]hether (1) the defendants are sued in their capacities as medical professionals, (2) the alleged negligence is of a specialized medical nature that arises out of the medical professional-patient relationship, and (3) the alleged negligence is substantially related to medical diagnosis or treatment and involved the exercise of medical judgment." "Regarding the second and third prongs, which are often considered together, a claim is properly characterized as medical malpractice when it involves a medical professional's judgment, but [w]hen medical personnel commit tortious acts that do not require medical knowledge, do not exercise medical judgment and are not related to medical diagnosis or treatment, such acts constitute ordinary negligence, not medical malpractice." (Internal quotation marks omitted.) *Marinara v. Waterbury Hospital,* Superior Court, judicial district of Waterbury, Docket No. CV–13–6017978–S (September 20, 2013, Zemetis, J.).

***7** General Statutes sec. 17a–550 permits a civil action for violations of sections 17a–540 to 17a–549. The plaintiff's complaint purports to allege violations of General Statutes sec. 17a–541, 17a–542 and 17–544(b). General Statutes sec. 17a–541 provides in relevant part that "[n]o patient hospitalized or treated in any public or private facility for the treatment of persons with psychiatric disabilities shall be deprived of any personal, property or civil rights, including the right to vote, hold or convey property, and enter into contracts, except in accordance with due process of law ..." General Statutes sec. 17a–542 provides that "[e]very patient treated in any facility for treatment of persons with psychiatric disabilities shall receive humane and dignified treatment at all times, with full respect for his personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his disorder. Such treatment plan shall include a discharge plan which shall include, but not be limited to, (1) reasonable notice to the patient of his impending discharge, (2) active participation by the patient in planning for his discharge and (3) planning for appropriate aftercare to the patient upon his discharge." General Statutes sec. 17a–544(b) provides that "[m]edication shall not be used as a substitute for an habilitation program."

Mahoney v. Lensink, 213 Conn. 548, 569 A.2d 518 (1990), is the seminal case interpreting the psychiatric patient bill of rights, and, in particular, what is now, General Statutes sec. 17a–541 and 17a–542. In *Mahoney,* the plaintiffs brought an action against the defendants after their son committed suicide. *Id.,* at 552, 569 A.2d

518. The plaintiffs alleged that their son, who suffered from mental illness, was a patient at Norwich Hospital, and that "the defendants' failure to provide proper counseling, medication, supervision or suicide precautions, so as to prevent the decedent from acting on his suicidal tendencies ... amounted to negligent, wanton, and willful misconduct which caused the death of their son." (Internal quotation marks omitted.) *Id.* The plaintiffs claimed that this alleged misconduct violated both General Statutes sec. 17–206b (now General Statutes sec. 17a–541) and sec. 17–206c (now General Statutes sec. 17a–542). *Id.*

The *Mahoney* court reviewed the history attending the enactment of the psychiatric patient bill of rights and found that "[e]xamination of the committee hearings on the senate bill that was eventually codified ... reveals that the act was intended to remedy the then prevailing conditions at state mental health facilities. The principal testimony was that of Walter Voight, who had been employed for four and one-half years at two of the state's mental health hospitals. First observing that 'my employment experience in Connecticut's Mental Hospitals consistently lend[s] credence to the notions that mental hospital patients are regularly exposed to various institutional policies and practices which deprive them of their basic human rights and which have a demoralizing and dehumanizing effect on the individual,' Voight then articulated the nexus between 'these [the state's] practices and procedures ... [and] those which [Senate Bill No.] 592 seeks to modify and control.' ... The most interesting revelation in Voight's testimony, however, is his reference to a report concerning an investigation at Fairfield Hills Hospital, a state mental health facility ... [The report] documented, in detail, the extent to which then prevailing practices at Fairfield Hills Hospital departed from the standards set by the American Psychiatric Association, and described the factors that it found to have contributed to 'the development and maintenance of a system which *inherently must result in violations and limitations of both human and civil rights.*' ... Having noted that '[t]he listed complaints have by now become classic legal problems in mental hospitals in many states, [that have been successfully resolved] by enactment of new legislation in New York and California' ... the task force report recommended that the legislature enact a patient's bill of rights to resolve problems that 'may be generic to all the State hospitals in Connecticut.' " (Citations omitted; emphasis added.) *Id.,* at 559–61, 569 A.2d 518.

***8** The court then went on to address the provisions of General Statutes sec. 17–206c (now General Statutes sec. 17a–542), which, at that time, provided in relevant part that "[e]very patient treated in any facility for treatment of the mentally disordered shall receive humane and dignified treatment at all times, with full respect for his personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his disorder."[9] (Internal quotation marks omitted.) *Mahoney v. Lensink, supra,* 213 Conn. at 550 n. 1, 569 A.2d 518. Our Supreme Court stated that this provision creates a new statutory tort cause of action "unknown to the common law, and therefore

independent of common law negligence." *Id.,* at 563, 569 A.2d 518. The court acknowledged that "the legislature chose not to attach a statutory definition to the phrase 'humane and dignified treatment,' " and, therefore, the court looked to the purpose of the statute as revealed by the legislative history and circumstances surrounding its enactment. *Id.*

The court determined that "[i]n its adoption of a statutory right to humane and dignified treatment, the legislature intended to afford patients a meaningful right to treatment, consistent with the requirements of good medical practice ... Meaningful treatment ... requires not only basic custodial care but also an individualized effort to help each patient by formulating, administering and monitoring a 'specialized treatment plan' as expressly mandated by sec. 17–206c." (Citation omitted.) *Id.,* at 565, 569 A.2d 518. The court noted, however, that "[t]he statutory responsibility for the formulation and subsequent monitoring of an appropriate treatment plan for each patient does not, however, encompass a guarantee that the treatment plan will invariably produce the desired results. A poor outcome may occur despite the best possible medical practice ... The standard for determining whether the provisions of sec. 17–206c have been violated thus cannot depend on the outcome of treatment. For similar reasons, the standard does not sound in negligence. To recover for a violation of the statute, a plaintiff must prove, as the statute prescribes ... that the conditions of his hospitalization were statutorily deficient. The plaintiff must allege and prove that the hospital failed initially to provide, or thereafter appropriately to monitor, an individualized treatment suitable to his psychiatric circumstances. In assessing whether the plaintiff has met his burden of proof, the trier of fact must inquire not whether the hospital has made the best decision possible but rather whether its treatment plan was permissible and reasonable in view of the relevant information available and within a broad range of discretion ... *The issue, under sec. 17–206c, is whether the hospital made good faith efforts to improve the patient's mental health and not whether it succeeded in fulfillment of this goal.*" (Citations omitted; emphasis added.) *Id.,* at 566–67, 569 A.2d 518.

***9** The court emphasized that, in determining whether a hospital's treatment plan was permissible and reasonable, the role of the trier of fact "is not to make independent judgments concerning treatment but rather to scrutinize the record to ensure that an expert more qualified than he has made a responsible exercise of his professional judgment. Courts have long fulfilled this role in supervising administrative agencies. Every regulatory agency is charged with the enforcement of a broad statute or statutes which require highly specialized training and knowledge; the legislature provides a broad standard, the administrator develops workable rules and procedures, and the court ensures that the standard and rules are evenhandedly applied to individuals. The role of the court in reviewing determinations of a mental health administrator should be similar to its role in any administrative review."[10] (Internal quotation marks omitted.) *Id.,* at n. 23.

Finally, the court considered the scope of the protections provided by General Statutes

sec. 17–206b (now General Statutes sec. 17a–541) which, at that time, provided in relevant part that "[n]o patient hospitalized or treated in any public or private facility for the treatment of the mentally disordered shall be deprived of any personal, property or civil rights, including the right to vote, hold or convey property, and contract, except in accordance with due process of law ..."[11] (Internal quotation marks omitted.) *Id.,* at 568, 569 A.2d 518. The court held that this provision "intended to secure for mental hospital patients *a state statutory remedy for the violation of substantive liberty interests similar to that provided by federal law under 42 U.S.C. sec.1983.*" (Emphasis added.) *Id.* The court explained that "an expansive construction of 'personal, property, or civil rights' is consistent with the usage and interpretation of similarly phrased rights guaranteed by 42 U.S.C. sec.1983. The scope of 42 U.S.C. sec.1983 is derived, in turn, from the mandates of the due process clause of the United States constitution, and includes not only those rights recognized by the Appellate Court that a patient holds absent hospitalization but more expansively encompasses a right to treatment that results because of hospitalization ... [T]he freedom from deprivation of 'any personal, property, or civil rights' provided in sec. 17–206b includes not only those statutory rights expressly enumerated, but necessarily incorporates as well the freedom from deprivation of 'any rights, privileges, or immunities secured by the Constitution' as guaranteed under 42 U.S.C. sec.1983." (Citations omitted.) *Id.,* at 569–70, 569 A.2d 518.

The court also determined that a claim under this provision must rise above negligence, explaining that "[t]he United States Supreme Court has held, in the context of sec.1983 actions, that acts of mere negligence do not violate an individual's rights under the due process clause of the United States constitution ..." (Citations omitted.) *Id.,* at 572, 569 A.2d 518. The court ultimately found that, since General Statutes sec. 17–206b "necessarily incorporates those rights afforded under 42 U.S.C. sec.1983," the plaintiffs' complaint, alleging the failure to restrict or control a patient so as to prevent suicide, was sufficient for purposes of alleging a violation of General Statutes sec. 17–206b, as facts similar to those alleged "have been held to be sufficient to allege such a degree of wanton neglect so as to state a cause of action for violation of a patient's rights under 42 U.S.C. sec.1983." (Internal quotation marks omitted.) *Id.*

***10** As explained in *Mahoney,* one of the major considerations in enacting the psychiatric patient bill of rights was that mental hospital patients were being "regularly exposed to various institutional policies and practices which [deprived] them of their basic human rights, which [had] a demoralizing and dehumanizing effect on the individual," and which contributed to "the development and maintenance of a system which *inherently must result in violations and limitations of both human and civil rights.*" (Emphasis in original; internal quotation marks omitted.) *Mahoney v. Lensink, supra,* 213 Conn. at 559–61, 569 A.2d 518. To remedy these issues, the psychiatric patient bill of rights codified the constitutional guarantees which must be afforded to all persons with psychiatric disabilities being treated in a facility for

treatment of such persons. See *Melville v. Sabbatino,* 30 Conn.Supp. 320, 324, 313 A.2d 886 (1973) ("[t]he act ... codifies certain constitutional guarantees which must be afforded to all patients in a hospital for the mentally disordered ..."). Indeed, our Supreme Court has described the psychiatric patient bill of rights as a statute addressing the civil rights of persons who are mentally ill, and has used its analysis in *Mahoney* as guidance for interpreting other statutes concerned with protecting the rights of individuals with mental difficulties. *Oller v. Oller–Chiang,* 230 Conn. 828, 839–40, 646 A.2d 822 (1994).[12]

In contrast, the purpose of General Statutes sec. 52–190a "is to prevent frivolous lawsuits against health care providers." *King v. Sultar,* 253 Conn. 429, 450, 754 A.2d 782 (2000); see *Dias v. Grady, supra,* 292 Conn. at 357, 972 A.2d 715 (initial purpose of General Statutes sec. 52–190a "was to prevent frivolous medical malpractice actions"); *Wilcox v. Schwartz,* 119 Conn.App. 808, 813–14, 990 A.2d 366 (2010), aff'd, 303 Conn. 630 (2012) ("purpose of sec. 52–190a is to 'inhibit a plaintiff from bringing an inadequately investigated cause of action, whether in tort or in contract, claiming negligence by a health care provider' "). In *Dias v. Grady, supra,* at 257–58, our Supreme Court described the history of the statute: "Section 52–190a originally was enacted as part of the Tort Reform Act of 1986 ... The original version of the statute required the plaintiff in any medical malpractice action to conduct 'a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the [plaintiff]' and to file a certificate 'that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant .' ... The original statute did not require the plaintiff to obtain the written opinion of a similar health care provider that there appeared to be evidence of medical negligence, but permitted the plaintiff to rely on such an opinion to support his good faith belief ... [T]he purpose of the original version of sec. 52–190a was to prevent frivolous medical malpractice actions ...

***11** "In 2005, the legislature amended sec. 52–190a(a) to include a provision requiring the plaintiff in a medical malpractice action to obtain the written opinion of a similar health care provider that 'there appears to be evidence of medical negligence' and to attach the opinion to the certificate of good faith to be filed with the complaint ... In addition, the amendment provided that the failure to file the written opinion would be grounds for dismissal of the complaint ... The legislative history of this amendment indicates that it was intended to address the problem that some attorneys, either intentionally or innocently, were misrepresenting in the certificate of good faith the information that they had obtained from experts." (Citations omitted.)

[1] The histories attending the enactments of the psychiatric patient bill of rights and General Statutes sec. 52–190a convinces this court that claims for violations of General Statutes sec. 17a–541, 17a–542 and 17a–544(b) are not subject to the requirements of General Statutes sec. 52–190a. The psychiatric patient bill of rights is a remedial act and, therefore, "must

be liberally construed in favor of those whom the legislature intended to benefit;" (Internal quotation marks omitted.) *Rutka v. Meriden,* 145 Conn.App. 202, 215 (2013); and "should be construed generously to accomplish its purpose." (Internal quotation marks omitted.) *Blakeslee v. Platt Bros. & Co.,* 279 Conn. 239, 245, 902 A.2d 620 (2006). The psychiatric patient bill of rights was clearly enacted to benefit patients receiving psychiatric treatment by ensuring the protection of their civil liberties. The duty owed under the psychiatric patient bill of rights is grounded in constitutional due process, and the humanitarian and constitutional purposes of the act would not be accomplished if General Statutes sec. 52–190a applied to conduct that the psychiatric patient bill of rights makes actionable in General Statutes sec. 17a–541, 17a–542 and 17a–544(b). Indeed, "[i]n giving a statute its full meaning where that construction is in harmony with the context and policy of the statute, there is no canon against using common sense in construing laws as saying what they obviously mean." (Internal quotation marks omitted.) *Singh v. Singh,* 213 Conn. 637, 655, 569 A.2d 1112 (1990). Moreover, this court is required to presume that the legislature, when it enacted General Statutes sec. 52–190a as part of the Tort Reform Act of 1986, was aware of the existing provisions set forth in the psychiatric patient bill of rights, which was enacted in 1971. See *Southern New England Telephone Co. v. Dept. of Public Utility Control,* 274 Conn. 119, 129, 874 A.2d 776 (2005) ("[w]e presume that the legislature is aware of existing statutes when enacting new ones"). "The legislature is presumed to be aware and to have knowledge of all existing statutes and the effect which its own action or nonaction may have on them." (Internal quotation marks omitted.) *Nunno v. Wixner,* 257 Conn. 671, 682, 778 A.2d 145 (2001); see *Mack v. Saars,* 150 Conn. 290, 298, 188 A.2d 863 (1963) ("[i]t is a well-recognized rule of statutory construction that the legislature is presumed to know all the existing statutes, the judicial interpretation of them, and the effect that its action or nonaction will have on them"). Based on the policies which the tort reform act and the psychiatric patient bill of rights seek to serve, there is no understandable reason why the legislature would have intended that General Statutes sec. 52–190a apply to the statutory cause of action authorized by the psychiatric patient bill of rights.

***12** This court finds that the cases cited by the defendant do not compel a different result. The defendant relies on a series of cases in which courts found that a plaintiff could not recast a medical malpractice claim as other causes of action. In *Haynes v. Yale New Haven Hospital,* 243 Conn. 17, 699 A.2d 964 (1997), the plaintiff sued the hospital and physician, who provided emergency health care after an automobile accident, alleging malpractice and claims under the Connecticut Unfair Trade Practices Act ("CUTPA"). Our Supreme Court held, *inter alia,* that professional malpractice does not fall under CUTPA. *Id.,* at 34, 699 A.2d 964. The court explained that "[a]lthough physicians and other health care providers are subject to CUTPA, only the entrepreneurial or commercial aspects of the profession are covered, just as only the entrepreneurial aspects of the practice of law are covered by CUTPA." *Id.* However, the court explained, further, that "[a] blanket

exemption for the medical profession would ... be improper ... We thus conclude that the touchstone for a legally sufficient CUTPA claim against a health care provider is an allegation that an entrepreneurial or business aspect of the provision of services is implicated, aside from medical competence or aside from medical malpractice based on the adequacy of staffing, training, equipment or support personnel. Medical malpractice claims recast as CUTPA claims cannot form the basis for a CUTPA violation. To hold otherwise would transform every claim for medical malpractice into a CUTPA claim." (Citation omitted.) *Id.,* at 38, 699 A.2d 964.

In *Rumbin v. Baez,* 52 Conn.App. 487, 490–91, 727 A.2d 744 (1999), the Appellate Court, citing, *inter alia, Haynes,* applied the entrepreneurial rule, striking a CUTPA claim against a clinical psychologist. The plaintiff had alleged that he was denied state services as a result of an evaluation conducted by the defendant, who, the plaintiff alleged, "was not qualified or competent to perform such tests but falsely represented himself as such for personal pecuniary gain." *Id.,* at 488–89, 727 A.2d 744. The court explained that "[t]he defendant in this case was a licensed clinical psychologist, maintained a clinical psychology practice and held himself out to the public as qualified to practice clinical psychology. The defendant's failure to meet the standards of that profession would constitute a malpractice claim." *Id.,* at 490, 727 A.2d 744. The court also struck the plaintiff's breach of contract claim and tortious interference claims. *Id.,* at 491, 727 A.2d 744. With regard to the breach of contract claim, the court acknowledged that a distinct claim may arise and exist where the physician and patient contract for a specific result, but found that the plaintiff's complaint contained "no allegations of a breach of a contractual duty owed to him ... [and] no allegation that the parties contracted for a specific result. The claim is essentially a medical malpractice claim clothed in the language of contract." *Id.,* at 491–92, 727 A.2d 744.

***13** The defendant, in the present case, also directs the court's attention to *Votre v. County Obstetrics & Gynecology Group, P.C.,* 113 Conn.App. 569, 966 A.2d 813, cert. denied, 292 Conn. 911, 973 A.2d 661 (2009), in which the court determined that a plaintiff's claims for infliction of emotional distress, breach of contract and misrepresentation sounded in medical malpractice as those claims arose from an alleged failure by physicians to refer the plaintiff for a consultation with high risk pregnancy specialists. The court applied *Trimel* and found that "[t]he claim certainly arises out of the professional-patient relationship between the defendants and the plaintiff, as the facts underlying the claim occurred solely in the context of the defendants' ongoing medical treatment of the plaintiff. The claim is of a 'specialized medical nature' because it directly involves the plaintiff's medical condition: her high risk pregnancy. To decide the issues presented by the plaintiff's complaint, a jury would require expert medical testimony. This is because the issues, including the proper scope of the relationship between a physician and his patient, the appropriate standard of care, which is the measure of the defendants' duty to the plaintiff, and whether the defendants' actions breached that standard, are beyond the knowledge of

the ordinary layperson ... The defendants' alleged acts also substantially are related to their medical diagnosis and treatment of the plaintiff and involved the exercise of their medical judgment." (Citation omitted.) *Id.,* at 577–78, 966 A.2d 813.

The foregoing cases demonstrate that a claim, the focus of which is on the level of skill exercised in the performance of the treatment, is likely to be a claim for medical malpractice. Notably, however, these cases also demonstrate that other causes of action, such as breach of contract and CUTPA, are available to address other aspects of health related services. These cases recognize that a plaintiff may have a variety of claims arising out of health related services that do not focus on the performance of the treatment. Indeed, in *Shortell v. Cavanagh,* 300 Conn. 383 (2011), our Supreme Court determined that General Statutes sec. 52–190a does not apply to a claim of lack of informed consent because such a claim is not a medical negligence claim. The court did not apply the three-part *Trimel* test, but instead relied on an earlier holding in *Logan v. Greenwich Hospital Ass'n.,* 191 Conn. 282, 293, 465 A.2d 294 (1983), which determined, on public policy grounds, that informed consent claims do not require expert testimony to establish the standard of care. *Shortell v. Cavanagh, supra,* at 388.

The *Shortell* court based its holding on two essential findings. First, the court determined that expert testimony is not necessary in order to establish the medical standard of care, as a claim for lack of informed consent is determined by a lay standard of materiality. *Id.,* at 388. Second, the court determined that "although ... sec. 52–190a does not explicitly limit the requirement of a written opinion letter to cases that require expert testimony, we have concluded herein that its application in a case that does not require expert testimony regarding the standard of care would lead to an absurd result." *Id.,* at 393. This is because "[u]nlike the traditional action of negligence, a claim for lack of informed consent focuses not on the level of skill exercised in the performance of the procedure itself but on the adequacy of the explanation given by the physician in obtaining the patient's consent." (Internal quotation marks omitted.) *Levesque v. Bristol Hospital, Inc.,* 286 Conn. 234, 253, 943 A.2d 430 (2008).

***14** Like a claim for lack of informed consent, claims for violations of General Statutes sec. 17a–541, 17a–542 and 17a–544(b) do not focus on the level of skill exercised in the performance of the treatment itself. For example, to recover for a violation of General Statutes sec. 17a–542, which entitles every patient to humane and dignified treatment, a plaintiff must prove "as the statute prescribes ... that the conditions of his hospitalization were statutorily deficient ... [T]he issue ... is whether the hospital made good faith efforts to improve the patient's mental health and not whether it succeeded in fulfillment of this goal." (Citations omitted.) *Mahoney v. Lensink, supra,* 213 Conn. at 566–67, 569 A.2d 518. In determining whether a breach has occurred, the trier of fact "*is not to make independent judgments concerning treatment but rather to scrutinize the record to ensure that an expert more qualified than he has made a responsible exercise of his professional judgment ... The role of the*

court in reviewing determinations of a mental health administrator should be similar to its role in any administrative review." Emphasis added; internal quotation marks omitted.) *Id.,* at 567 n. 23, 569 A.2d 518. Similarly, a claim for violation of General Statutes sec. 17a–541 focuses on whether the plaintiff was deprived of his due process rights. Finally, the focus of General Statutes sec. 17a–544(b) is upon whether medication was used as a substitute for an habilitation program. Indeed, although it is conceivable that expert testimony may be necessary to establish a breach of these provisions of the psychiatric patient bill of rights—an issue which is not before this court—such a requirement would not automatically convert this statutory cause of action into one for medical negligence.

As this court finds that General Statutes sec. 52–190a does not apply to claims for violations General Statutes sec. 17a–541, 17a–542 and 17a–544(b), this court must now review the plaintiff's complaint to determine whether it falls within the conduct that the psychiatric patient bill of rights makes actionable.

B

Plaintiff's Complaint[13]

[2] Count one of the plaintiff's complaint alleges that the defendant deprived the plaintiff of her right to independently contract with an employer and to negotiate lawful accommodations pursuant to the ADA, in violation of General Statutes sec. 17a–541, which provides that "[n]o patient hospitalized or treated in any public or private facility for the treatment of persons with psychiatric disabilities shall be deprived of any personal, property or civil rights, including the right to vote, hold or convey property, and enter into contracts, except in accordance with due process of law ..." This provision incorporates those rights afforded under 42 U.S.C. sec.1983. *Mahoney v. Lensink, supra,* 213 Conn. at 569–72, 569 A.2d 518. Although a claimed violation of the ADA is not actionable under 42 U .S.C. sec.1983; see *Alsbrook v. Maumelle,* 184 F.3d 999 (8th Cir.1999), cert. dismissed, 529 U.S. 1001, 120 S.Ct. 1265, 146 L.Ed.2d 215 (2000); the ADA is a comprehensive civil rights law that prohibits discrimination on the basis of disability. 42 U.S.C. sec. 12101(b)(1). This court finds that an alleged interference with a psychiatric patient's exercise of civil rights afforded by the ADA is conduct that the psychiatric patient bill of rights makes actionable.

***15** Whether the plaintiff has, indeed, alleged facts sufficient to state a cause of action under General Statutes sec. 17a–541 is not before this court on the defendant's motion to dismiss. A motion to dismiss "essentially asserts that, as a matter of law and fact, a plaintiff cannot state a cause of action that is properly before the court ... By contrast, [a] motion to strike attacks the sufficiency of the pleadings ... There is a significant difference between asserting that a plaintiff *cannot* state a cause of action and

asserting that a plaintiff *has not* stated a cause of action, and therein lies the distinction between the motion to dismiss and the motion to strike." (Citations omitted; emphasis added; internal quotation marks omitted.) *Pecan v. Madigan,* 97 Conn.App. 617, 621, 905 A.2d 710 (2006), cert. denied, 281 Conn. 919, 918 A.2d 271 (2007).

As the plaintiff's claims are not subject to General Statutes sec. 52–190a, and count one alleges conduct that the psychiatric patient bill of rights makes actionable, this court has subject matter jurisdiction over count one. The defendant's motion to dismiss count one is, therefore, denied.

Count two alleges that the defendant used medication as a substitute for an habilitation program in violation of General Statutes sec. 17a–544(b).[14] Certainly, the plaintiff has alleged a violation of General Statutes sec. 17a–544(b) that is actionable under the psychiatric patient bill of rights. Count two also alleges that the defendant violated General Statutes sec. 17a–542 by failing to order the appropriate medications and quantities thereof from the pharmacy, with gross disregard for the dignity of the patient and with a lack of regard for the health and welfare of the plaintiff. Count two further alleges that the plaintiff followed the treatment schedule set forth by the defendant, but, nonetheless, was deprived of the medication she was instructed to take.

[3] General Statutes sec. 17a–542 provides in relevant part that "[e]very patient treated in any facility for treatment of persons with psychiatric disabilities shall receive humane and dignified treatment at all times, with full respect for his personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his disorder." In *Mahoney v. Lensink, supra,* 213 Conn. at 565, 569 A.2d 518, our Supreme Court explained that "[i]n its adoption of a statutory right to humane and dignified treatment, the legislature intended to afford patients a meaningful right to treatment," which requires "an individualized effort to help each patient by formulating, administering and monitoring a 'specialized treatment plan' ..." This court finds that the allegations that the defendant wrongfully failed to order the appropriate medications is conduct that the psychiatric patient bill of rights makes actionable. See *Mahoney v. Lensink, supra,* 213 Conn. at 567, 569 A.2d 518 (allegations of failure to provide proper counseling, medication, supervision or suicide precautions held sufficient to state a cause of action under General Statutes sec. 17a–542). Whether the plaintiff has, indeed, alleged facts sufficient to state a cause of action under General Statutes sec. 17a–544(b) and 17a–542 is not before this court on the defendant's motion to dismiss. As the plaintiff's claims are not subject to General Statutes sec. 52–190a, and count two alleges conduct that the psychiatric patient bill of rights makes actionable, this court has subject matter jurisdiction over count two. The defendant's motion to dismiss count two is, therefore, denied.

***16** Count three alleges that the defendant failed to develop or implement a discharge plan for the plaintiff, failed to provide reasonable notice of her impending discharge, failed to include the plaintiff in planning for her discharge, and failed to plan for appropriate aftercare of the patient, all in

violation of General Statutes sec. 17a–542. General Statutes sec. 17a–542 provides that "[e]very patient treated in any facility for treatment of persons with psychiatric disabilities shall receive humane and dignified treatment at all times, with full respect for his personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his disorder. Such treatment plan shall include a discharge plan which shall include, but not be limited to, (1) reasonable notice to the patient of his impending discharge, (2) active participation by the patient in planning for his discharge and (3) planning for appropriate aftercare to the patient upon his discharge." Under this provision, a plaintiff has a right to be an active participant in her treatment plan. The treatment plan must include a discharge plan and the patient is allowed to participate in planning for discharge. As the plaintiff in the present case has alleged that she was deprived of these rights, such conduct is actionable under the psychiatric patient bill of rights.

Whether the plaintiff has, indeed, alleged facts sufficient to state a cause of action under General Statutes sec. 17a–542 is not before this court on the defendant's motion to dismiss. As the plaintiff's claim is not subject to General Statutes sec. 52–190a, and count three alleges conduct that the psychiatric patient bill of rights makes actionable, this court has subject matter jurisdiction over count three. The defendant's motion to dismiss count three is, therefore, denied.

V

CONCLUSION

This court holds that claims for violations of General Statutes sec. 17a–541, 17a–542 and 17a–544 are not subject to the requirements of General Statutes sec. 52–190a. As the conduct alleged by the plaintiff falls within the scope of the statutory protections, this court has subject matter jurisdiction. The motion to dismiss (# 101) is, therefore, denied.

So ordered.

All Citations

Not Reported in A.3d, 2014 WL 660486, 57 Conn. L. Rptr. 546

Footnotes

1 The complaint alleges that the defendant is a facility for the diagnosis, observation or treatment of persons with psychiatric disabilities with the meaning of General Statutes sec. 17a–540(1), and that the plaintiff was a person with a mental disorder within the meaning of General Statutes sec. 17a–540(2) and (3).

2 General Statutes sec. 17a–541 provides that "[n]o patient hospitalized or treated in any public or private facility for the treatment of persons with psychiatric disabilities shall be deprived of any personal, property or civil rights, including the

right to vote, hold or convey property, and enter into contracts, except in accordance with due process of law, and unless such patient has been declared incapable pursuant to sections 45a–644 to 45a–662, inclusive. Any finding of incapability shall specifically state which civil or personal rights the patient is incapable of exercising."

3 "Medication shall not be used as a substitute for an habilitation program." General Statutes sec. 17a–544(b).

4 "Every patient treated in any facility for treatment of persons with psychiatric disabilities shall receive humane and dignified treatment at all times, with full respect for his personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his disorder. Such treatment plan shall include a discharge plan which shall include, but not be limited to, (1) reasonable notice to the patient of his impending discharge, (2) active participation by the patient in planning for his discharge and (3) planning for appropriate aftercare to the patient upon his discharge." General Statutes sec. 17a–542.

5 The defendant also moved to dismiss on the ground that the recognizance of a person to prosecute the action was not signed, in violation of General Statutes sec. 52–185 and Practice Book sec. 8–3 and 8–4. At oral argument, the defendant indicated that it was not pursuing this ground for dismissal.

6 Section 52–190a(a) specifies that a party bringing a medical malpractice action must comply with the following requirements: "[make] a reasonable inquiry ... to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint ... shall contain a certificate of the attorney or party filing the action ... that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant ... To show the existence of such good faith, the claimant or the claimant's attorney ... shall obtain a written and signed opinion of a similar health care provider ... that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion." Section 52–190a(c) provides that "[t]he failure to obtain and file the written opinion required by subsection (a) of this section shall be grounds for dismissal of the action." The good faith certificate and written and signed opinion are "akin to ... [pleadings] that must be attached to the complaint in order to commence properly the action." *Morgan v. Hartford Hospital,* 301 Conn. 388, 398 (2011). The failure to comply with sec. 52–190a "constitutes insufficient service of process ... [and] implicates personal jurisdiction." *Id.,* at 402. "A plaintiff's failure to comply with the requirements of sec. 52–190a(a) ... render her complaint subject to dismissal pursuant to sec. 52–190a(c)." *Votre v. County Obstetrics & Gynecology Group, P.C.,* 113 Conn.App. 569, 583, 966 A.2d 813, cert. denied, 292 Conn. 911, 973 A.2d 661 (2009).

7 In *Simmons,* the court found that "a fair reading of the complaint reveals that the plaintiff's claims do sound in medical malpractice rather than ordinary negligence. The allegations of the complaint, which were repeated throughout the counts, stated that the defendants undertook to provide pharmaceutical care to the plaintiff and deviated from the appropriate standards of care. Significantly, the plaintiff also alleged that she specifically consulted with CVS' pharmacists regarding whether the tablets she received were proper and in conformance with her prescription. It is clearly alleged that the defendants were providing professional services, namely pharmaceutical care, in the course of a medical professional-patient relationship by providing prescription medication and consultation regarding that medication. The negligent acts of providing the wrong prescription medication and assuring the plaintiff that she had received the appropriate medication were, at the very least, substantially related to the pharmaceutical care she received from the defendants ... The defendants exercised specialized medical judgment and skill by assuring the plaintiff that she had received the proper medication. Although the defendants' acts may be obviously negligent to the trier of fact, the distinction between ordinary negligence and malpractice does not hinge on whether expert testimony would be required to establish a standard of care and breach ... Therefore, the plaintiff's claims sound in medical malpractice and a written opinion letter and certificate of good faith are required pursuant to General Statutes sec. 52–190a." (Citations omitted.)

8 The defendants also moved to strike the entire complaint on the ground that the plaintiff failed to filed the good faith certificate required by General Statutes sec. 52–190a. The court did not reach the issue of whether each of the eight counts of the plaintiff's complaint required such a filing, as the plaintiff had, indeed, filed a good faith certificate. *Id.*

9 That provision was subsequently transferred and is now General Statutes sec. 17a–542, which provides that "[e]very patient treated in any facility for treatment of persons with psychiatric disabilities shall receive humane and dignified treatment at all times, with full respect for his personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his disorder. Such treatment plan shall include a discharge plan which shall include, but not be limited to, (1) reasonable notice to the patient of his impending discharge, (2) active participation by the patient in planning for his discharge and (3) planning for appropriate aftercare to the patient upon his discharge."

10 Our Supreme Court ultimately determined that the plaintiffs' complaint adequately stated a cause of action for violation of General Statutes sec. 17–206c. *Id.,* at 567, 973 A.2d 661.

11 That provision was subsequently transferred and is now General Statutes sec. 17a–541, providing that "[n]o patient hospitalized or treated in any public or private facility for the treatment of persons with psychiatric disabilities shall be deprived of any personal, property or civil rights, including the right to vote, hold or convey property, and enter into contracts, except in accordance with due process of law, and unless such patient has been declared incapable pursuant to sections 45a–644 to 45a–662, inclusive. Any finding of incapability shall specifically state which civil or personal rights the patient is incapable of exercising."

12 In *Oller,* our Supreme Court was guided by the *Mahoney* court's application of canons of statutory construction in interpreting General Statutes sec. 45a–675, which, "like the statute at issue in *Mahoney* ... is concerned with protecting the rights of individuals with mental difficulties." *Oller v. Oller–Chiang, supra,* 230 Conn. at 838–39, 646 A.2d 822.

13 Although the court has diligently identified those factual allegations that are relevant to the disposition of the defendant's motion, the court notes that many of the allegations contained within the ninety-seven (97) paragraphs that comprise the plaintiff's three-count complaint are repetitious, immaterial, improper and unnecessary. See Practice Book sec. 10–1 and 10–35.

14 "Medication shall not be used as a substitute for an habilitation program." General Statutes sec. 17a–544(b).

Attachment B

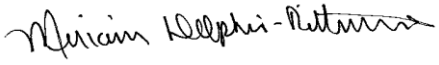
DMHAS Commissioner's Policy 6.41

Community Integration

STATE OF CONNECTICUT
Department of Mental Health & Addiction Services

Department of Mental Health and Addiction Services

Commissioner's Policy Statement and Implementing Procedures

SUBJECT:	Community Integration and Discharge from Connecticut Valley Hospital
P & P NUMBER:	Chapter 6.41
APPROVED:	Miriam Delphin-Rittmon, Ph.D., Commissioner 
EFFECTIVE DATE:	May 20, 2015
REVISED:	NEW
REFERENCES:	
FORMS AND ATTACHMENTS:	

STATEMENT OF PURPOSE:

The purpose of this document is to establish guidelines for Connecticut Valley Hospital (CVH) to promote timely community integration for the individuals hospitalized in that facility. It is CVH's objective to discharge persons whom it serves to a setting that maximizes their opportunity to interact to the fullest extent possible with persons who do not have disabilities, unless it would constitute a fundamental alteration of services.

POLICY:

Taking into account the limits of court imposed confinement; CVH shall actively pursue the appropriate discharge of persons deemed discharge ready by their treatment team who are receiving services at CVH. CVH shall pursue the provision of services in the most integrated, appropriate setting that is consistent with each person's needs and to which they can be reasonably be accommodated, taking into account the resources available to the State and the needs of others with psychiatric disabilities. CVH shall also take into account the informed choice of the individual or his/her conservator with authority, or other legal representative, if applicable, including whether the placement is opposed.

CVH emphasizes that treatment planning is a collaborative endeavor between clinicians and patients. Treatment planning will also focus on discharge, and discharge planning should be based on an approach that "sets the bar high" at the most integrated setting and works down when necessary, rather than requiring the individual to work up a ladder and earn opportunities for

independence and self-determination. Individuals will be encouraged to pursue education, employment, valued roles, and social activities in their communities.

PROCEDURE:

It is recognized that training, supervision and accountability are required to operate a system at CVH that promotes timely community integration. In order to create an environment that promotes and supports such a system, CVH shall have procedures that address the following objectives related to hospital discharge-planning, transition from hospital to outpatient status, and timely community integration:

1. Planning for discharge to the most integrated community setting begins upon admission to the inpatient service and treatment planning shall address the particular considerations for each individual bearing on discharge and identify barriers to discharge.
2. At every treatment plan review the treating physician will document in the chart and discuss with the patient the specific factors that the physician is considering to determine the patient's current clinical need for hospital level of care and the patient's readiness for discharge. Such factors should include the patient's physical and mental status, results of medical/psychological tests, the patient's cognitive and behavioral status, the patient's functional capacities, and evaluative explorations or treatment protocols yet to be completed. The physician will also document in the chart the treatment interventions the hospital will provide to address each factor in order to discharge the patient from the hospital in a timely manner once the patient is deemed discharge ready by the treatment team. Extrinsic factors which present barriers to discharge, such as the patient's willingness to leave the hospital or the availability of a residential placement must be documented in the chart. While these barriers may impact the patient's actual discharge, they are not relevant to the physician's decision about the patient's clinical state of readiness for discharge.
3. Discharge planning must be directed toward the most integrated, least restrictive environment appropriate for each individual, maximizing the individual's opportunity to interact with persons who do not have disabilities and take into account the informed choice of the individual or his/her conservator with authority, or other legal representative,, if applicable. When addressing discharge planning, treatment teams shall begin with the presumption that supportive housing, which is housing with supportive services that can be adjusted to meet the individual's needs, is the most integrated setting generally. Treatment teams will then explore whether supportive housing is the most integrated setting appropriate for the needs of the individual. The rationale for discharge to a setting other than supportive housing shall be clearly documented in the chart and supported by clinical findings or otherwise that confirm the person's inability to reside in supportive housing.
4. Individuals who no longer need hospital level of care, as determined by the individual's treatment team, shall be discharged as expeditiously as possible. It is recognized that, in some cases, treatment teams may not have control of certain systemic barriers, and teams must bring these cases to the attention of supervisors in a timely manner. Those persons who are not discharged within ninety (90) days shall have a right to a case conference within ten days (10) with the DMHAS Medical Director. The objective of the case conference shall be to review and overcome, where possible, impediments to discharge.

5. When a CVH treatment team determines that an individual no longer needs hospital level of care, the team will chart the person as discharge ready, specify the least restrictive community living arrangement appropriate for that individual, the specific barriers to discharge to that setting, and a schedule for implementing the discharge plan, taking into account the resources available to the State and the needs of others with mental disabilities and the individual's or his/her legal representative's informed choice.

Attachment C

CVH Policy 2.38
Community Integration

CONNECTICUT VALLEY HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION I:	**Patient Focused Functions**
CHAPTER 2:	**Assessment**
PROCEDURE:2.38	**Community Integration and Discharge**
REVISED:	**New 06/04/2015**
Governing Body Approval	June 11, 2015

Policy:

Taking into account the limits of court imposed confinement; the hospital actively pursues the appropriate discharge of persons deemed discharge ready by their treatment team who are receiving services. The hospital pursues the provision of services in the most integrated, appropriate setting that is consistent with each person's needs and to which they can be reasonably be accommodated, taking into account the resources available to the State and the needs of others with psychiatric disabilities. The hospital also takes into account the informed choice of the individual or his/her conservator with authority, or other legal representative, if applicable, including whether the placement is opposed.

Treatment planning is a collaborative endeavor between clinicians and patients. Treatment planning will also focus on discharge, and discharge planning should be based on an approach that "sets the bar high" at the most integrated setting and works down when necessary, rather than requiring the individual to work up a ladder and earn opportunities for independence and self-determination. Individuals will be encouraged to pursue education, employment, valued roles, and social activities in their communities.

Discharge planning is a collaborative clinical process that begins at the time of admission and continues throughout the individual's hospitalization. The preferences of the individual and his/her family, significant others and conservators are identified and incorporated into the discharge planning process. All treatment plans should include the individual's strengths, personal preferences, and goals. Challenges to a successful discharge are also identified. This process ensures the safety, well-being and continuity of care for the individual in the least restrictive setting possible.

Clinical social workers maintain a knowledge base of community support services and provide oversight to the discharge planning process. The discharge planning process is documented in the psychosocial history and assessment, clinical social work progress notes and the individualized treatment plan.

PROCEDURE:

It is recognized that training, supervision and accountability are required to operate a system that promotes timely community integration. In order to create an environment that promotes and supports such a system, the hospital has procedures that address the following objectives related to hospital discharge-planning, transition from hospital to outpatient status, and timely community integration:

1. Planning for discharge to the most integrated community setting begins upon admission to the inpatient service and treatment planning shall address the particular considerations for each individual bearing on discharge and identify barriers to discharge.

2. At every treatment plan review the treating physician will document in the chart and discuss with the patient the specific factors that the physician is considering to determine the patient's current clinical need for hospital level of care and the patient's readiness for discharge. Such factors should include the patient's physical and mental status, results of medical/psychological tests, the patient's cognitive and behavioral status, the patient's functional capacities, and evaluative explorations or treatment protocols yet to be completed. The physician will also document in the chart the treatment interventions the hospital will provide to address each factor in order to discharge the patient from the hospital in a timely manner once the patient is deemed discharge ready by the treatment team. Extrinsic factors which present barriers to discharge, such as the patient's willingness to leave the hospital or the availability of a residential placement must be documented in the chart. While these barriers may impact the patient's actual discharge, they are not relevant to the physician's decision about the patient's clinical state of readiness for discharge.

3. Discharge planning must be directed toward the most integrated, least restrictive environment appropriate for each individual, maximizing the individual's opportunity to interact with persons who do not have disabilities and take into account the informed choice of the individual or his/her conservator with authority, or other legal representative,, if applicable. When addressing discharge planning, treatment teams shall begin with the presumption that supportive housing, which is housing with supportive services that can be adjusted to meet the individual's needs, is the most integrated setting generally. Treatment teams will then explore whether supportive housing is the most integrated setting appropriate for the needs of the individual. The rationale for discharge to a setting other than supportive housing shall be clearly documented in the chart and supported by clinical findings or otherwise that confirm the person's inability to reside in supportive housing.

4. Individuals who no longer need hospital level of care, as determined by the individual's treatment team, shall be discharged as expeditiously as possible. It is recognized that, in some cases, treatment teams may not have control of certain systemic barriers, and teams must bring these cases to the attention of supervisors in a timely manner. Those persons who are not discharged within ninety (90) days shall have a right to a case conference within ten days (10) with the DMHAS Medical Director. The objective of the case conference shall be to review and overcome, where possible, impediments to discharge.

5. When a treatment team determines that an individual no longer needs hospital level of care, the team will chart the person as discharge ready, specify the least restrictive community living arrangement appropriate for that individual, the specific barriers to discharge to that setting, and a schedule for implementing the discharge plan, taking into account the resources available to the State and the needs of others with mental disabilities and the individual's or his/her legal representative's informed choice.

Attachment D

WFH Policy 2.38
Community Integration

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 2:	Assessment
PROCEDURE: 2.38	**Community Integration and Discharge**
Governing Body Approval:	6/10/18
REVISED:	

POLICY:

Taking into account the limits of court imposed confinement; the hospital actively pursues the appropriate discharge of persons deemed discharge ready by their treatment team who are receiving services. The hospital pursues the provision of services in the most integrated, appropriate setting that is consistent with each person's needs and to which they can be reasonably be accommodated, taking into account the resources available to the State and the needs of others with psychiatric disabilities. The hospital also takes into account the informed choice of the individual or his/her conservator with authority, or other legal representative, if applicable, including whether the placement is opposed.

Treatment planning is a collaborative endeavor between clinicians and patients. Treatment planning will also focus on discharge, and discharge planning should be based on an approach that "sets the bar high" at the most integrated setting and works down when necessary, rather than requiring the individual to work up a ladder and earn opportunities for independence and self-determination. Individuals will be encouraged to pursue education, employment, valued roles, and social activities in their communities.

Discharge planning is a collaborative clinical process that begins at the time of admission and continues throughout the individual's hospitalization. The preferences of the individual and his/her family, significant others and conservators are identified and incorporated into the discharge planning process. All treatment plans should include the individual's strengths, personal preferences, and goals. Challenges

to a successful discharge are also identified. This process ensures the safety, well-being and continuity of care for the individual in the least restrictive setting possible.

Clinical social workers maintain a knowledge base of community support services and provide oversight to the discharge planning process. The discharge planning process is documented in the psychosocial history and assessment, clinical social work progress notes and the individualized treatment plan.

PROCEDURE:

It is recognized that training, supervision and accountability are required to operate a system that promotes timely community integration. In order to create an environment that promotes and supports such a system, the hospital has procedures that address the following objectives related to hospital discharge-planning, transition from hospital to outpatient status, and timely community integration:

1. Planning for discharge to the most integrated community setting begins upon admission to the inpatient service and treatment planning shall address the particular considerations for each individual bearing on discharge and identify barriers to discharge.

2. At every treatment plan review the treating physician will document in the chart and discuss with the patient the specific factors that the physician is considering to determine the patient's current clinical need for hospital level of care and the patient's readiness for discharge. Such factors should include the patient's physical and mental status, results of medical/psychological tests, the patient's cognitive and behavioral status, the patient's functional capacities, and evaluative explorations or treatment protocols yet to be completed. The physician will also document in the chart the treatment interventions the hospital will provide to address each factor in order to discharge the patient from the hospital in a timely manner once the patient is deemed discharge ready by the treatment team. Extrinsic factors which present barriers to discharge, such as the patient's willingness to leave the hospital or the availability of a residential placement must be documented in the chart. While these barriers may impact the patient's actual discharge, they are not relevant to the physician's decision about the patient's clinical state of readiness for discharge.

3. Discharge planning must be directed toward the most integrated, least restrictive environment appropriate for each individual, maximizing the individual's opportunity to interact with persons who do not have disabilities and take into account the informed choice of the individual or his/her conservator with authority, or other legal representative,, if applicable. When addressing discharge

planning, treatment teams shall begin with the presumption that supportive housing, which is housing with supportive services that can be adjusted to meet the individual's needs, is the most integrated setting generally. Treatment teams will then explore whether supportive housing is the most integrated setting appropriate for the needs of the individual. The rationale for discharge to a setting other than supportive housing shall be clearly documented in the chart and supported by clinical findings or otherwise that confirm the person's inability to reside in supportive housing.

4. Individuals who no longer need hospital level of care, as determined by the individual's treatment team, shall be discharged as expeditiously as possible. It is recognized that, in some cases, treatment teams may not have control of certain systemic barriers, and teams must bring these cases to the attention of supervisors in a timely manner. Those persons who are not discharged within ninety (90) days shall have a right to a case conference within ten days (10) with the DMHAS Medical Director. The objective of the case conference shall be to review and overcome, where possible, impediments to discharge.

5. When a treatment team determines that an individual no longer needs hospital level of care, the team will chart the person as discharge ready, specify the least restrictive community living arrangement appropriate for that individual, the specific barriers to discharge to that setting, and a schedule for implementing the discharge plan, taking into account the resources available to the State and the needs of others with mental disabilities and the individual's or his/her legal representative's informed choice.

Attachment E

Law Office of Norman Voog, LLC

v.

Stevens

2004 WL 3130526

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.
Superior Court of Connecticut,
Judicial District of Danbury.

LAW OFFICE OF NORMAN VOOG, LLC
v.
Jane C. STEVENS et al.

No. CV020347140S.
|
Dec. 17, 2004.

Attorneys and Law Firms

Christopher Winans, Danbury, Nuzzo & Roberts LLC, Cheshire, for Law Offices/Norman J. Voog LLC.

Jane C. Stevens, Ridgefield, pro se.

Frederick Stevens, Ridgefield, pro se.

Cohen & Wolf Pc, Bridgeport, for Jane C. Stevens and Frederick Stevens.

Tooher & WOCL LLC, Stamford, for Nonparty Witness/Brenden P. Leydon.

Opinion

SHAY, J.

***1** The case comes before this court by way of a lawsuit by the plaintiff herein claiming legal fees for services rendered to the defendants herein in connection with another matter. The defendants, in turn, have filed a counterclaim with two counts, speaking in both breach of fiduciary duty and a CUTPA claim. The defendants filed an Amended Counterclaim (# 131.05) dated March 30, 2004, which added claims of professional negligence (First and Second Counts) as well as a breach of agreement (Third Count). The First and Second Counts of the original Counterclaim became the Fourth and Fifth Counts of the Amended Counterclaim. The plaintiff has filed a Motion to Strike (# 158) dated October 12, 2004, seeking to strike the Third, Fourth, and Fifth Counts of the Amended Counterclaim, as well as certain prayers for relief thereon.

In brief, the basis of plaintiff's argument is that the Third Count of the Amended Counterclaim must fail because it is in reality a negligence claim denominated as a claim of breach of contract. As to the Fourth Count, he asserts the argument that a claim of breach of fiduciary duty based upon negligence and/or violation of the Rules of Professional Conduct is improper. Finally, as to the Fifth Count, he argues that the facts of the case do not give rise to a CUTPA claim.

The parties have each filed memoranda of law in support of their respective positions. The court heard argument of counsel and took the papers.

DISCUSSION

"It is fundamental that in determining the sufficiency of a complaint challenged by a defendant's motion to strike, all well-pleaded facts and those facts necessarily implied from the allegations are taken as admitted." (Internal quotation marks omitted.) *Commissioner of Labor v. C.J.M. Services, Inc.,* 268 Conn. 283, 292, 842 A.2d 1124 (2004). "For the purpose of ... [a] motion to strike [the moving party] admits all facts well pleaded." (Internal quotation marks omitted.) *Clohessy v. Bachelor,* 237 Conn. 31, 33 n. 4, 675 A.2d 852 (1996). "For the purpose of ruling upon a motion to strike, the facts alleged in a complaint, though not the legal conclusions it may contain, are deemed to be admitted." (Internal quotation marks omitted.) *Murillo v. Seymour Ambulance Assn., Inc.,* 264 Conn. 474, 476, 822 A.2d 1202 (2003).

While it is clear that a plaintiff may assert a claim for negligence and breach of contract in the same complaint, the alleged breach of contract must not arise from the negligent acts of the defendant, but rather, it must arise out of a breach of the terms of the contract itself. In other words, the breach of contract claim must not, in essence, be a negligence claim cloaked in contract language. *Caffery v. Stillman,* 79 Conn.App. 192, 197 (2003); *Alexandru v. Strong,* 81 Conn.App. 68, 79-80, cert. denied, 268 Conn. 906 (2004). The Third Count in the defendant's Amended Counterclaim mirrors precisely the claims of legal malpractice in the First and Second Counts. Likewise, the allegations of breaches of the Rules of Professional Conduct fail to support the claim for breach of contract.

***2** In the Fourth Count, the defendants assert a breach of fiduciary duty based upon breaches of the Rules of Professional Conduct. That issue was settled by the Appellate Court in *Standish v. Sotavento Corp.,* 58 Conn.App. 789, 796-97 (2000). In that case, the court granted summary judgment, holding that: "Violation of a Rule [of the Rules of Professional Conduct] should not give rise to a cause of action nor should it create any presumption that a legal duty has been breached. The Rules are designed to provide guidance to lawyers and to provide a structure for regulating conduct through disciplinary agencies. They are not designed to be a basis for civil liability."

The provisions of the Connecticut Unfair Trade Practices Act, more familiarly referred to as "CUTPA," are set forth in General Statutes § 42-110a et seq. Unfair trade practices are defined as, "unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce." General Statutes § 42-110b(a). The Connecticut Supreme Court has held that CUTPA applies to the practice of law. *Beverly Hills Concepts, Inc. v. Schatz & Schatz, Ribicoff & Kotkin,* 247 Conn. 48, 79 (1998).

Connecticut courts have adopted the so called "cigarette rule" in order to determine whether or not a certain practice is unfair. *Willow Springs Condominium Assn., Inc. v. Seventh BRT Dev. Corp.,* 245 Conn. 1 (1998). Briefly stated, the rule provides that: "(1) [W]hether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the

common law, or otherwise-in other words, it is within at least the penumbra of some common law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive, or unscrupulous; (3) whether it causes substantial injury to consumers, [competitors or other business persons] ... All three criteria do not need to be satisfied to support a finding of unfairness. A practice may be unfair because of the degree to which it meets one of the criteria or because to a lesser extent it meets all three." (Internal quotation marks omitted.) *Id.,* at 43. In reviewing the allegations contained in the Fifth Count of the Amended Counterclaim, the court finds that the defendants' pleading contains sufficient claims implicating the entrepreneurial aspects of the practice of law to meet the test of the "cigarette rule," in particular, the allegations regarding the retainer and the billing for legal services.

In addition, for the sake of clarity of pleading,[1] the court believes that it is appropriate to strike certain paragraphs, and/or portions thereof, pursuant to Practice Book § 10-45. The court aligns itself with a minority of Superior Court decisions in a broader interpretation of that Rule. *Nordling v. Harris,* Superior Court, judicial district of Fairfield, Docket No. 329660 (August 7, 1996, Levin, J.) (17 Conn. L. Rptr. 296). That section should be read as a whole when attempting to interpret it. The majority would equate the words "any portion" with the word "paragraph." This court believes that is too narrow. The rule uses that phrase twice, and, in addition, the word "portion" once. A portion is, quite simply, anything less than a whole. The whole in question is either a "pleading" or a "count." This makes sense when read in the context of the effect of the motion to strike. Where the paragraph is removed from a pleading or count, and it "states or constitutes *a part of another cause of action or defense,*" it is removed from the case, except to the extent that the matter "is applicable to any other cause or action or defense." It is not logically consistent to hold that a paragraph can be stricken if, and only if, it states an entire cause of action or defense, when the rule itself recognizes that, for purposes of preserving that cause of action in another count, the stricken paragraph may constitute only a part of the cause of action or defense.

***3** Moreover, the court believes that some of the decisions interpreting Practice Book § 10-45 rest upon a misreading of the landmark case *of Rossignol v. Danbury School of Aeronautics,* 154 Conn. 549 (1967). In that case, for the first time, the Connecticut Supreme Court set forth the minimum essential allegations of a cause of action based on the tort of strict liability. However, that point was very nearly lost in what the court referred to as, "a gordian knot of procedural difficulties owing to a failure of the parties to observe elemental rules of pleading and practice." *Id .,* at 552. The decision was rendered prior to the 1978 Practice Book change and during the heyday of the now dead demurrer. Citing *Veits v. Hartford,* 134 Conn. 428 (1948), the court acknowledged that while the joinder of multiple causes of action in one count was permitted, the practice was "a hazardous and complicating one" especially in a case where there were multiple defendants. *Rossignol v. Danbury School of Aeronautics, supra,* 154 Conn. at 552. Since the plaintiffs had failed to aver an essential element in their claim of

strict tort liability, the court did, in fact, sustain the demurrer to a portion of two counts of the complaint, striking material therefrom, "only so far as those counts purport to allege a cause or causes of action based on liability other than on grounds of negligence." *Id.,* at 563.[2] In the view of this court, the proper reading of *Rossignol* is found in the case of *Akridge v. Nastri,* Superior Court, judicial district of New Haven, Docket No. LPL-CV-01-0451972S (September 5, 2003, Lager, J.). There the court found: "When some of the allegations contained in a count are sufficient to set forth the cause of action, the court is not permitted to strike the entire count." See also, *Doyle v. A & P Realty Corporation,* 36 Conn.Sup. 126, 127 (1980).

Therefore, the court strikes certain paragraphs and portions of paragraphs of the Fifth Count for two reasons: (1) For the foregoing reasons, this court sees no logical reason why the rule only applies where the stricken paragraph contains an entire cause of action when, in most instances, most complaints set forth a cause of action in multiple paragraphs. The stricken paragraphs can and should be read as a unified whole, and dealt with as such; and (2) because the court struck the Fourth Count in its entirety, and the portions stricken from the Fifth Count are, for the most part, a reiteration of those contained in the Fourth Count.

ORDERS

For the foregoing reasons the Motion to Strike is HEREBY GRANTED as to the Third and Fourth Counts of the Amended Counterclaim, and it is HEREBY GRANTED IN PART AND DENIED IN PART as to the Fifth Count thereof. Specifically, so much of Paragraph 8 of the Fifth Count that refers to a violation of the Rules of Professional Conduct together with Paragraphs 13 through 17 thereof, as well as so much of Paragraph 18 which refers to a breach of fiduciary duty, are HEREBY STRICKEN. The remaining paragraphs, or portions thereof, of the Fifth Count shall remain part of the Amended Counterclaim. The Motion to Strike portions of the Claims for Relief is HEREBY DENIED.

All Citations

Not Reported in A.2d, 2004 WL 3130526, 38 Conn. L. Rptr. 433

Footnotes

1 The court is aware of the fact that it is to a certain extent, "hoist on its own petard," since it had earlier sustained the objections to plaintiff's Request to Revise (# 140) which addressed some of the same issues.

2 In so doing, the court, by implication, held that the stricken portions of both counts did not state or constitute an entire cause of action (i.e., strict tort liability).

38 Conn. L. Rptr. 433

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